

Mercer Island High School Athletic Injury Return-to-Play Form

Please take this form to your physician appointment to be filled out. This form must be completed and returned to the Athletic Trainer or faxed to (206) 230-6316 before returning to sport participation.

Patient's Name: _____ Date: _____

Reason for visit: _____

Injury Clearance Status (check option and fill in information)

___ Patient is **fully** cleared to return to _____ (sport) as of date above.
Any special care or treatment (bracing, taping, icing protocol): _____

___ Patient is able to return to **partial** activity for _____ (sport) as of date above.

Partial activity includes: ___ Running
___ Exercise Bike ___ Swimming
___ Stretching ___ Weight Lifting
___ Sport Specific Drills
___ Light Aerobic ___ Non-Contact Practice
___ Other: _____

___ Patient is **not cleared** to return to any activity as of date above.
A follow up appointment is scheduled for:

Place office stamp or attach business card here:

Concussion Clearance Status (check option and fill in information)

Patient was seen on date above for suspicion of a concussion.
___ Patient is allowed to return to **full activity** as of date above. **No concussion diagnosed.**

___ Patient has a **confirmed concussion** and presents with the following symptoms:
___ Headache ___ Nausea ___ Confusion
___ Balance problems ___ Dizziness
___ Vision Problems ___ Feels Sluggish
___ Sensitive to Light ___ Sensitive to Noise
___ Memory Problems ___ Feels Foggy
___ Recall Problems *prior to event after event*
(circle appropriate option(s))
___ Personality Changes
___ Other: _____

___ Patient should follow monitored return-to-play protocol (each step is separated by 24 hours). Back up 1 day if any symptoms return.

- No activity and rest until asymptomatic
- Light aerobic exercise
- Sport-specific exercise
- Noncontact drills
- Full-contact drills
- Game play

If prefer other return-to-play protocol, please attach your instructions to this sheet.

___ Patient will be seen by treating doctor again on: _____ (date)

___ Patient is being **referred** for further testing/evaluation to:

Physician's Signature: _____ Date: _____

Physician's Name: _____ Phone: _____